



**MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE
April 25, 2022**

The State Employee Benefits Committee (the “Committee”) met at 2:00 p.m. on April 25, 2022. The meeting was held at 97 Commerce Way, Suite 201, in Dover; however, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, participants had the option to attend this meeting virtually via WebEx in addition to the option to attend in person.

Committee Members Represented or in Attendance:

Director Cerron Cade, Office of Management & Budget (“OMB”), SEBC Co-Chair
Secretary Claire DeMatteis, Department of Human Resources (“DHR”), SEBC Co-Chair
Mr. Keith Warren Chief of Staff, Office of the Lt. Governor (Designee OBO The Honorable Bethany Hall-Long, Lieutenant Governor, Office of the Lieutenant Governor)
The Honorable Chief Justice Collins Seitz, Delaware Supreme Court
Ms. Tanisha Merced, Deputy Insurance Commissioner, DOI (Designee OBO The Honorable Trinidad Navarro, Insurance Commissioner, Department of Insurance (“DOI”))
Controller General Ruth Ann Jones, Office of the Controller General (“OCG”)
Mr. Daniel Madrid, Chief Operating Officer, Office of the State Treasurer (Designee OBO The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer (“OST”))
Secretary Molly Magarik, Department of Health & Social Services (“DHSS”)
Mr. Jeff Taschner, Executive Director, Delaware State Education Association (“DSEA”)

Others in Attendance

Director Faith Rentz, Statewide Benefits Office (“SBO”), DHR	Ms. Julie Greenwood, University of Delaware
Deputy Director Leighann Hinkle, SBO, DHR	Ms. Charlene Hrivnak, CVS Health
Mr. Aaron Schrader, SBO, DHR	Ms. Heather Johnson, Controller, DHR
Deputy Attorney General Adria Martinelli, Dept. of Justice (“DOJ”), SEBC Legal Counsel	Mr. Jamie Johnstone, Deputy Principal Assistant, Dept. of Finance (“DOF”)
Mr. Chris Giovannello, Willis Towers Watson (“WTW”)	Ms. Lisa Mantegna, Highmark Delaware
Ms. Jaclyn Iglesias, WTW	Ms. Jeanie Carson, Highmark Delaware
Mr. Brian Stitzel, WTW	Mr. Adam Knox, Highmark Delaware
Ms. Rebecca Warnken, WTW	Mr. Walt Mateja, IBM Watson Health
Ms. Gabby Costagliola, WTW	Ms. Kathy Nedelka, HRIS Specialist, PHRST, OMB
Ms. Joanna Adams, Pension Administrator, Office of Pensions (“OPen”)	Ms. Judi Schock, Deputy Principal Assistant, OMB
Ms. Wendy Beck, Highmark Delaware	Mr. Mike Shipley, Highmark Delaware
Mr. Ken Bronke, Highmark Delaware	Mr. Charles Simons, Highmark Delaware
Ms. Julie Caynor, Aetna	Ms. Ashley Tucker, Deputy State Court Administrator, Admin Office of the Courts
Ms. Katherine Impellizzeri, Aetna	Ms. Jessilene Corbett, Deputy Secretary, DHR
Ms. Brooke Nedza, Aetna	Ms. Judy Anderson, Executive Director, DSEA
Mr. Michael North, Aetna	Ms. Christine Schiltz, Parkowski Guerke & Swayze, P.A.
Mr. Steven Costantino, Dir. Healthcare Reform, DHSS	Ms. Paula Roy, Roy Associates
Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR	Ms. Christina Bryan, Delaware Healthcare Association
Ms. Sara Dunlevy, CVS Health	Mr. Kollin Jensen, Teledoc Health
	Ms. Mary Jo Condon, Freedom Health Care (“FHC”)

STATE OF DELAWARE STATEWIDE BENEFITS OFFICE

Ms. Jeanette Hammon, OMB
Mr. Anthony Onugu, United Medical
Ms. Meagan Iwaskiewicz, OPeN
Ms. Kristal Diaz, OPeN

Ms. Stephenie Tatman, Deputy Pension Administrator,
OPen
Ms. Carole Mick, SBO, DHR – Recorder

CALLED TO ORDER – DIRECTOR FAITH RENTZ, DHR, SBO

Director Rentz called the meeting to order at 2:04 p.m.

APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ, DHR, SBO

A MOTION was made by Mr. Taschner and seconded by Secretary DeMatteis to approve the minutes from the March 14, 2022, meeting of the State Employee Benefits Committee.

MOTION ADOPTED UNANIMOUSLY

DIRECTOR'S REPORT – DIRECTOR FAITH RENTZ, DHR, SBO

House Bill 303

The SBO and the Subcommittees are following House Bill 303 very closely and an amendment has been filed. This would mandate that insurance plans including the GHIP would have to offer coverage to members to receive an annual preventive well check with a licensed behavioral health provider. The bill was released from the House Health Committee on April 13th and the estimated fiscal impact to the GHIP is \$2.4 million annually. Estimated effective date would be January 2024 and estimated fiscal impact to the GHIP if the bill is signed into law would not apply until FY24.

Medicare Advantage Implementation

Director Rentz shared an update on the Medicare Advantage implementation and weekly meetings with Highmark on implementation having been occurring with the SBO and Pension Office. Committee members received a draft event timeline and comparison document that analyzes the existing Medicfill plan to the proposed Highmark Freedom Blue Medicare Advantage plan. The first mailing that will be coming from the State of Delaware to Medicare state pensioners will be mailed the first week in June. This will be followed by additional mailings that will come directly from Highmark in August. In October, there will be mailings sent throughout the tentatively scheduled open enrollment period of October 3rd through October 24th.

MEDICARE ADVANATAGE WITH AND WITHOUT PRESCRIPTION COVERAGE PLAN OPTIONS – DIRECTOR FAITH RENTZ, DHR, SBO

Ms. Rentz began with stating that Committee members are being asked to consider this agenda item as evaluation continues through the implementation of the Medicare Advantage Plan. Committee members will need to vote on, whether to consider no longer offering a Medicare Pensioner health plan option without prescription drug coverage. At the February 28th meeting, the Committee approved the rates for the Medicare pensioner plan options and those proposed options were voted on to replace the current plans in place today. At the March 14th meeting, the Committee approved the implementation of the Medicare Advantage plan for the January 1, 2023 plan year. Enrollment today for the Medicfill with drug coverage is 27,526 pensioners/spouses, enrollment without drug coverage is 689 pensioners/spouses, and 5,089 pensioners/spouses are eligible for State Medicare coverage but are not enrolled.

Ms. Rentz stated that as far back as 2002, the State has continuously offered Medicare supplement plans with the option of selecting that plan with or without prescription coverage. Prior to the prescription plan in place today with CVS/SilverScript, the prescription drug coverage was identical to what was offered to active employees and non-Medicare pensioners.

Ms. Rentz reviewed some of the primary reasons why State pensioners or spouses eligible for State Medicare coverage would not enroll in State Medicare coverage to include: not being enrolled in Medicare Part A and B as required, retired from another company that offers coverage, not eligible for 100% State share and the cost of the State Medicare plan is unaffordable, or purchased an individual Medicare Part D prescription plan. CMS coordination rules currently impact enrollment in the State EGWP plan for pensioners or spouses currently enrolled in another group or individual plan. The CMS rules will apply as well to the State Medicare Advantage plan in January.

Ms. Rentz continued that today the ask is that the Committee consider reducing the plan options to just one: Medicare Advantage with the SilverScript Part D prescription plan effective January 1, 2023. This would impact enrollment for individuals who have already chosen another plan that does not coordinate and a targeted communication will be sent to those individuals explaining the coordination issues. The premiums for the Medicare Advantage product effective January 1st, 2023 as approved by the Committee in mid-March are significantly less than the premiums for the Medicfill and Medicfill with prescription drug coverage today.

In closing, Ms. Rentz shared with the Committee that the SBO reviewed a three year lookback of data from IBM Watson to determine why some participants would choose Medicfill without a prescription drug option. The utilization data supports the theory that members who are enrolled in the Medicfill medical only plan are enrolled because it is a cheaper option, and those members are less likely to use their medical services compared to those who are enrolled in the Medicfill with prescription drug coverage option.

Secretary DeMatteis commented that she could understand how some retirees are getting very conflicting information with all the medical and drug plan options and it is wise to simplify the options. She supports the change. Secretary Magarik questioned, what type of communications are going to be sent to pensioners? Director Rentz responded that the communication plan is still in the development phase, however, there is a larger communication allowance from Highmark to support the implementation. SBO will hire additional resources to support the Pension Office before, during, and after open enrollment. There will also be specific and targeted communications to those individuals who are enrolled in the Medicfill without prescription drug option to ensure that every effort is made to assist them in understanding why the decision to eliminate this option was made and ease their transition.

FEBRUARY AND MARCH STATE OF DELAWARE HEALTH FUND REPORT – MR. CHRIS GIOVANNELLO, WTW

Mr. Giovannello reviewed the February fund report and indicated that February was a rebate month. The commercial rebates were close to budget around \$14.6 million and the EGWP rebates were above budget \$9.7 million (versus \$7.8 million budgeted and this has been consistent with the last few months of EGWP rebates). No adjustments will be made at this point to the budget as the CVS rebates will be presented in May and at that point the WTW team will reassess. Claims were above budget (by \$6.5 million) for February at \$89.5 million compared to \$83 million that had been budgeted (year-to-date still below budget overall). In February net income was reported to be about \$3.5 million.

Mr. Giovannello reviewed the March fund report and indicated there was no substantial movement under Other Revenues. March claims were around budget at \$93 million (budgeted was \$93.4 million). The deficit for March was \$23.4 million compared to \$24.7 million projected. This brought the fund equity balance down to \$147.2 and actual year-to-date variance of \$28.3 million (after reserves, current surplus is about \$61.9 million).

Director Cade questioned if there are there any expectations that there are claims that have not yet been incurred. Mr. Giovannello responded that there is a higher invoice that was issued in April for the Highmark population (\$12 million claim). No expectation of any other high-cost claimants.

COVID-19 BENEFIT ENHANCEMENTS – MS. JACLYN IGLESIAS, WTW

Ms. Iglesias reviewed that there are some considerations around COVID-19 benefit enhancements that were put into place during the COVID-19 pandemic and are due to expire in the upcoming months. These include benefits such as waiving cost share for any treatment with the diagnosis of COVID-19, extending EAP coverage for all State employees, and extending COBRA election periods.

The National Emergency Declaration was recently extended by President Biden to April 1st, 2023. This has an impact to the Outbreak Period Guidance providing extended deadlines for several benefit-related actions including making COBRA elections, COBRA premium payments, or requesting HIPAA special enrollments. All of these transactional items have experienced extended deadlines because of the extension of the Outbreak Period Guidance.

The Public Health Emergency which was issued by the Federal department of the Health and Human Services has extended this period to July 15th, 2022. This Public Health Emergency is in effect for all group health plans which are required to extend coverage for several COVID-19 diagnosis and treatment services. The State has continuously been compliant. In addition, there are other benefit enhancements that the State has opted to put into effect for the GHIP and these benefit changes are tied to the Public Health Emergency. Aligning the extension of these benefit enhancements to the National Emergency Declaration would bring greater consistency to how all benefit enhancements are administered by the GHIP. It would be more consistent to communicate to members of when the enhancements are coming to an end.

An additional benefit enhancement that the State offered was the pre-tax commuter (PTC) benefit that removed claim deadlines during the pandemic. Some employees who had unused PTC funds were able to utilize any unused funds to date before being required to start contributing new pre-tax funds to their commuter accounts. The consideration for the SEBC is to allow all plan participants to access unused PTC funds to pay for services incurred prior to restarting contributions, continuing until at least 30 days following the end of the National Emergency Declaration and further evaluated at that point to consider the status/impact of the I-95 corridor project.

Ms. Iglesias closed with asking the SEBC to consider voting on aligning extension of COVID-19 benefit enhancements to the National Emergency Declaration. Secretary DeMatteis questioned what the main reason is for not aligning with the State of Delaware's Public Health Emergency and instead aligning with the National Emergency Declaration. Ms. Iglesias responded that the rationale is around consistency, better planning, aligned communications, and having participants keep just one date in mind rather than multiple dates for various enhancements. Secretary DeMatteis asked how many other States are going with the National Emergency Declaration. Ms. Iglesias responded that she will take that as a follow up. Secretary DeMatteis added that it is the right thing to do. It will just be something that we have to budget for and have the State funds budgeted to cover those costs. Ms. Iglesias referenced the three-month cost estimates for extending those benefits which were included in the presentation materials for this agenda item. Director Cade questioned if the intent was to align with other COVID-related programs that relate to the other Federal guidelines. Ms. Rentz responded that was correct. Director Cade stated that for planning purposes, he suggested that the SEBC delay the vote to allow more time to review these considerations.

FY21 STRATEGIC FRAMEWORK DASHBOARDS AND GOAL DISCUSSION – MS. REBECCA WARNKEN, WTW

Ms. Warnken began with stating that today's discussion is strictly informational and to provide a status update on the Statewide Benefits Office (SBO) strategic plan and updates on progress toward achievement of the GHIP Strategic Framework goals. These goals were implemented in February 2020 as either replacement to or enhancements of the goals that have been previously satisfied in the prior period.

Ms. Warnken discussed the various updates of the four goals which include: the use of the Alternative Payment Model (APM) Framework to increase GHIP spend through APMS, increase users utilizing consumerism tools by 5%, reduce GHIP diabetic cost per-member-per-month by 8%, and limit total cost of care inflation for GHIP participants. Some of the goals of these initiatives encompass conducting RFPs, providing instructor-led training, sending our communications, promoting consumer tools and programs, and using scorecards to rank organizations in achieving key metrics.

Ms. Warnken continued with mentioning additional SBO initiatives which included: the Disability Insurance Program assessment, Dental RFP, HIPAA risk assessment, Healthcare and Actuarial Consulting RFP, and the ongoing Retiree Benefits Study Committee work.

PRIMARY CARE LEGISLATION IMPLEMENTATION – MS. MARY JO CONDON, OFFICE OF VALUE BASED HEALTH CARE DELIVERY and MS. TANISHA MERCED, DEPUTY INSURANCE COMMISSIONER, DOI

Ms. Condon presented an overview of the new law from Senate Bill (SB) 120 that focuses on strengthening the primary care system within the State of Delaware. Ms. Condon reviewed the historical path of SB 120 and how the bill came to inception. A report was developed with three key recommendations to achieving the goals of what SB 120 hopes to accomplish. The three key recommendations are centered on increasing primary care investment, limiting price growth for certain non-professional services (mainly inpatient hospital, outpatient hospital, and other medical services), and expanding alternative payment model adoption within Delaware.

Ms. Condon then reviewed the three main components of SB 120 that have been assigned to the Department of Insurance to implement. The primary care investment increases is essentially paid for through a limit on unit price growth and through improvement of value-based care delivery across the State. The DOI also heard that carriers needed clear requirements to implement more appropriate price increases for hospitals and other services to free up dollars for the primary care investment. Providers needed to be offered meaningful opportunities to share in the gains and, when appropriate, be responsible for the losses.

Ms. Condon shared the types of primary care capabilities that the Primary Care Reform Collaborative (PCRC) has imagined year to date. They are in the middle of their process and those capabilities may evolve further.

Ms. Condon reiterated that the legislation does not require the State Group Health Plan to meet the requirements of the legislation. Those requirements are applicable and are required for the fully insured market, however self-insured carriers are encouraged to extend coverage for those requirements. The requirements include maintaining Medicare parity, increase primary care investment as a percentage of total spend, limit non-professional price growth to core CPI +1, and expand alternative payment model adoption.

Ms. Condon continued that PCPs will be required to engage in care transformation in order for Delaware to achieve a robust system of primary care as intended by the General Assembly. Carrier obligation is in aggregate across Delaware PCPs engaged in care transformation and some providers will get more and some will get less. PCPs can take several different avenues to participate in care transformation programs. Multi-payer alignment is necessary to have sufficient primary care investment needed to enable providers to transform care delivery across patients. There is also a risk of self-insured purchasers shouldering additional hospital price growth to offset fully insured limits (which has been addressed during the meetings that occurred with other carriers).

Mr. Taschner asked if the primary care model has been pushed down to physician assistants rather than physicians, along with is this a fundamental question of reimbursement and is there discussion whether this is incentivizing physicians to be part of the transformation. Ms. Condon explained that the vision put forward by the PCRC is of care teams with a strong role from physicians. Ms. Merced added that due to the lack of primary care physician capacity within the State, they have to hire other physicians assistants/nurse practitioners.

DIABETES CARE MANAGEMENT PROGRAMS – MS. JACLYN IGLESIAS, WTW

Ms. Iglesias stated that a key decision that the SEBC should consider and potentially take a vote on at the conclusion of the meeting related to the diabetes care management options. Ms. Iglesias gave an overview of the Livongo program and reviewed its offerings since it was implemented from July 1, 2019. Livongo provides all enrolled participants with a “connected meter” through wireless technology to transmit blood glucose test results to Livongo coaches. Members today are aware of the program through the broader care management program, some targeted member outreach, and larger communication efforts. The key takeaway regarding the utilization metrics is consistent with previous findings shared with the Subcommittees in October 2021, that the GHIP enrollment is lower than expected (15% vs Livongo book of business (BOB) range 20-25%), but once enrolled, connected meter activation at 98% is very high (vs. Livongo BOB range: 85%-90%).

Ms. Iglesias presented additional information on the GHIP’s outcomes and results since implementation of the program on July 1, 2019. Those who are using the connected meters are engaged with Livongo on average 19 times a month (Livongo’s BOB is 20-23 times/month). Livongo provided data showing an average reduction in estimate A1c for activated members at 6 or more months. The ROI measured at \$1.1 million for the cost of the program and \$0.6 million in estimated net savings. Overall, GHIP members rated Livongo a Net Promoter Score (NPS) of +69 (a measure of how likely someone would recommend Livongo to a friend/family member, on a scale of -100 to +100, Livongo’s BOB NPS of +54).

Ms. Iglesias stated that Aetna is sunsetting its relationship with Livongo, which will not be available to Aetna HMO and CDHP Gold plan participants (effective June 30, 2022). Aetna has proposed their diabetes care management program called Transform Diabetes Care (TDC) that was launched with CVS Health (Aetna’s parent company) on January 1, 2022. The decision point is if the State should offer the TDC program to all plan participants (Aetna and Highmark) or continue with Livongo for Highmark participants and TDC for Aetna participants.

Ms. Iglesias added that with the decision to implement the TDC program, the State can choose to either contract with Aetna or CVS Health to implement the program (both options have additional considerations). For Highmark members additionally, there is the option to add TDC through the CVS contract or maintain Livongo through the Highmark contract.

Ms. Iglesias pointed out that there are some key differences between TDC and Livongo. For TDC, the glucose meter used by program participants is different and only those who are the highest risk participants receive a connected meter. Those lower risk participants that do want to participate in the program would receive a formulary meter. Ms. Iglesias stated that TDC offers further coaching/counseling options, program participants can call or text diabetes coaching nurses, and go to an in-person counseling session on nutrition. TDC also provides vouchers for two screenings (A1c test, blood pressure, foot exam, retinopathy scan) per year at a CVS HealthHUB at no cost to program participants. Additionally, they can redeem vouchers for virtual visits focused on lifestyle and comorbidity management. There are no GHIP-specific results available yet, given the program isn’t in place for any Commercial plans and was only available for EGWP starting January 1, 2022. CVS did provide detail on TDC outcomes for another Commercial population.

This was reviewed with the Subcommittees during the April 21, 2022 meeting and there was consensus among Subcommittee members about the following recommendations: for Highmark members – retain Livongo for FY23 and for Aetna members – implement TDC through Aetna contract for FY23. The SEBC is being asked to consider voting on the diabetes care management program options. As a reminder, anticipated changes in Aetna’s offerings effective 7/1/2022 will be visible to HMO and CDH Gold plan participants even if no action is taken by the SEBC today.

Secretary DeMatteis asked if there were any outcomes data available for TDC. Ms. Iglesias responded that there had been previous materials presented to the Subcommittee showing that TDC has demonstrated some reasonably successful results in engaging diabetic members to make positive behavior changes to close gaps in care. The program has been largely piloted in other populations and only been in place with the EGWP population for four months (results aren't available yet). WTW can provide more information after the meeting.

OTHER BUSINESS

No new business was presented.

PUBLIC COMMENT

No public comment was presented.

APPROVAL OF MEDICARE ADVANTAGE WITH AND WITHOUT PRESCRIPTION COVERAGE PLAN OPTIONS – DIRECTOR RENTZ

For January 1, 2023, the SEBC is being asked to offer only the Medicare Advantage with prescription coverage.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to approve the Medicare Advantage Plan with prescription as the only Medicare pensioner option.

MOTION ADOPTED UNANIMOUSLY

Keith Warren is voting on behalf of the Honorable Bethany Hall-Long.
Tanisha Merced is voting on behalf of the Honorable Trinidad Navarro.

APPROVAL OF DIABETES CARE MANAGEMENT PROGRAMS – DIRECTOR RENTZ

For FY23, the SEBC is being asked for Highmark members to retain the Livongo diabetes management program and for Aetna members that the SEBC approve implementation the TDC diabetes care management program through the Aetna contract.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to retain the Livongo diabetes care management plan through Highmark contract and implement TDC through Aetna contract.

MOTION ADOPTED UNANIMOUSLY

Keith Warren is voting on behalf of the Honorable Bethany Hall-Long.
Tanisha Merced is voting on behalf of the Honorable Trinidad Navarro.

EXECUTIVE SESSION

A MOTION was made by Director Cade and seconded by Mr. Taschner to move into Executive Session for discussions related to the GHIP FY21 spend through the APM Framework at 3:38 p.m.

MOTION ADOPTED UNANIMOUSLY.

ADJOURNMENT

A MOTION was made by Mr. Taschner and seconded by Secretary Magarik to adjourn the Public Session at 4:30 p.m.

MOTION ADOPTED UNANIMOUSLY

Respectfully submitted,

Carole Mick, Executive Secretary, Statewide Benefits Office, Department of Human Resources
Recorder, State Employee Benefits Committee, and Subcommittees